



Early Head Start
Application for Enrollment
Serving Pregnant Women, Infants and Toddlers up to age 3

I am applying for:

Home Visiting Program (weekly visits)

Center-Based

First Available (Home Visiting or Center-Based)

Adult Name: _____

First MI Last

Date of Birth: _____

Father
 Mother
 Other

Address: _____

Street Apt. # P.O. Box

City State Zip County

This address is: House/Apartment Friend/Relative's House Motel/Shelter/Temporary Housing

Primary Language: English Spanish Other: _____

Were you under 20 years old when your first child was born? Yes No

Are you currently pregnant? Yes No If yes, due date: _____

Were you referred by local agency (CPS, Foster care, WIC)? Yes No If yes, by whom: _____

Does your family receive Supplemental Food Assistance (SNAP)? Yes No

Family Income Information: Eligibility is based on child's age, family income, child's need, and available openings.

	Total Gross Income	Time Period of Total Income	Source of Income (check all that apply)			
Parent 1	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	<input type="checkbox"/> Working <input type="checkbox"/> SSI	<input type="checkbox"/> Child Support <input type="checkbox"/> SSD	<input type="checkbox"/> DHHS Financial <input type="checkbox"/> Other: _____	
Parent 2	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	<input type="checkbox"/> Working <input type="checkbox"/> SSI	<input type="checkbox"/> Child Support <input type="checkbox"/> SSD	<input type="checkbox"/> DHHS Financial <input type="checkbox"/> Other: _____	

Child 1 Name: _____

First MI Last

Date of Birth: _____

Male
 Female

Child 2 Name: _____

First MI Last

Date of Birth: _____

Male
 Female

Do any of the above children have a special need (IFSP) or a home visitor (Early On, health care visitor)? Yes No If yes, which child: _____

Worker Name/Agency: _____

Other Family Members Living in Home:

Name	Date of Birth	Relationship to Child(ren)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Make additional notes regarding recent income changes, family size, or other concerns on the back of application.

I certify that the above information is correct and true to the best of my knowledge. I authorize the release of this information and educational records to be shared between EightCAP, Inc. 0-5 Head Start and any Intermediate School District.

Signature: _____ **Date:** _____

Return application to: Early Head Start 5827 Orleans Rd, Orleans, MI 48865 **Apply online:** www.8cap.org
 Fax: 616-754-9310 Email: deniseb@8cap.org Phone: 616-754-9315, option 2

State & Federally funded programs will not discriminate against anyone because of race, color, national origin, sex, age or disability.

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